

		FOR OHF USE					

LL 1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0033506</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Walnut Grove Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1095 Twilight Drive</u> <u>Morris</u> <u>60450</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Grundy</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(815) 942-5108</u> Fax # <u>(815) 942-6877</u>		(Type or Print Name) <u>Harris F. Webber</u>	
IDPA ID Number: <u>36-3549632-002</u>		(Title) <u>President, Managing Agent</u>	
Date of Initial License for Current Owners: <u>3/6/89</u>		(Signed) _____ (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) <u>James M. Ridenour</u> <u>Crowe Chizek & Co. LLP</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) <u>330 E. Jefferson Blvd PO Box 7</u> <u>South Bend, IN 46624</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(574) 236-8636</u> Fax # <u>(574) 239-7871</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Mark A. Hull, CPA</u> Telephone Number: <u>(574) 239-7883</u>			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Walnut Grove Village# 0033506 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>24</u>	Sheltered Care (SC)	<u>24</u>	<u>8,760</u>	5
6		ICF/DD 16 or Less			6
7	<u>123</u>	TOTALS	<u>123</u>	<u>44,895</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,129</u>	<u>12,527</u>	<u>5,039</u>	<u>30,695</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>7,097</u>		<u>7,097</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,129</u>	<u>19,624</u>	<u>5,039</u>	<u>37,792</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 84.18%

D. How many bed-hold days during this year were paid by Public Aid?

238 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 3/6/89

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date _____

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 17 and days of care provided 5,039Medicare Intermediary AdminaStar Federal, Kentucky

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Walnut Grove Village

0033506

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	183,665	26,679	10,099	220,443		220,443		220,443		1
2	Food Purchase		232,680		232,680		232,680	(3,169)	229,511		2
3	Housekeeping	160,188	19,595		179,783		179,783		179,783		3
4	Laundry	50,654	13,858		64,512		64,512	(17,681)	46,831		4
5	Heat and Other Utilities			119,320	119,320		119,320		119,320		5
6	Maintenance	82,011	2,743	48,924	133,678		133,678		133,678		6
7	Other (specify):*										7
8	TOTAL General Services	476,518	295,555	178,343	950,416		950,416	(20,850)	929,566		8
	B. Health Care and Programs										
9	Medical Director			10,200	10,200		10,200		10,200		9
10	Nursing and Medical Records	1,443,215	65,285	4,639	1,513,139		1,513,139		1,513,139		10
10a	Therapy	20,004	1,066	293,832	314,902		314,902		314,902		10a
11	Activities	67,317	615	6,068	74,000		74,000		74,000		11
12	Social Services	68,308		798	69,106		69,106		69,106		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,598,844	66,966	315,537	1,981,347		1,981,347		1,981,347		16
	C. General Administration										
17	Administrative	94,895		297,512	392,407		392,407	25,358	417,765		17
18	Directors Fees										18
19	Professional Services			56,487	56,487		56,487		56,487		19
20	Dues, Fees, Subscriptions & Promotions			11,316	11,316		11,316	(2,061)	9,255		20
21	Clerical & General Office Expenses	93,615	19,510	20,975	134,100		134,100	(2,037)	132,063		21
22	Employee Benefits & Payroll Taxes			484,992	484,992		484,992		484,992		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,260	9,260		9,260	(692)	8,568		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			124,025	124,025		124,025	(2,899)	121,126		26
27	Other (specify):*										27
28	TOTAL General Administration	188,510	19,510	1,004,567	1,212,587		1,212,587	17,669	1,230,256		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,263,872	382,031	1,498,447	4,144,350		4,144,350	(3,181)	4,141,169		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Walnut Grove Village

#0033506

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			188,300	188,300		188,300		188,300			30
31	Amortization of Pre-Op. & Org.			3,780	3,780		3,780		3,780			31
32	Interest			235,452	235,452		235,452	(5,218)	230,234			32
33	Real Estate Taxes			78,214	78,214		78,214		78,214			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,492	21,492		21,492		21,492			35
36	Other (specify):*											36
37	TOTAL Ownership			527,238	527,238		527,238	(5,218)	522,020			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		161,554	9,939	171,493		171,493		171,493			39
40	Barber and Beauty Shops			20,754	20,754		20,754		20,754			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*	27,975	701	160,729	189,405		189,405	(189,405)				43
44	TOTAL Special Cost Centers	27,975	162,255	245,625	435,855		435,855	(189,405)	246,450			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,291,847	544,286	2,271,310	5,107,443		5,107,443	(197,804)	4,909,639			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Walnut Grove Village# 0033506

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,169)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,037)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(17,681)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,218)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(15,000)	17		17
18	Fines and Penalties				18
19	Entertainment	(692)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance	(2,899)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,061)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Cottages</u>	(189,405)	43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (238,162)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	40,358	17	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 40,358		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (197,804)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Walnut Grove Village

ID# 0033506

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Cottage Expense	\$ (189,405)	43	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(189,405)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walnut Grove Village

0033506

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,169)	0	0	0	0	0	0	0	0	0	0	(3,169)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(17,681)	0	0	0	0	0	0	0	0	0	0	(17,681)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,850)	0	0	0	0	0	0	0	0	0	0	(20,850)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	25,358	0	0	0	0	0	0	0	0	0	0	25,358	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,061)	0	0	0	0	0	0	0	0	0	0	(2,061)	20
21	Clerical & General Office Expenses	(2,037)	0	0	0	0	0	0	0	0	0	0	(2,037)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(692)	0	0	0	0	0	0	0	0	0	0	(692)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,899)	0	0	0	0	0	0	0	0	0	0	(2,899)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	17,669	0	0	0	0	0	0	0	0	0	0	17,669	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,181)	0	0	0	0	0	0	0	0	0	0	(3,181)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walnut Grove Village# 0033506

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,218)	0	0	0	0	0	0	0	0	0	0	(5,218)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,218)	0	0	0	0	0	0	0	0	0	0	(5,218)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(189,405)	0	0	0	0	0	0	0	0	0	0	(189,405)	43
44	TOTAL Special Cost Centers	(189,405)	0	0	0	0	0	0	0	0	0	0	(189,405)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(197,804)	0	0	0	0	0	0	0	0	0	0	(197,804)	45

Facility Name & ID Number Walnut Grove Village# 0033506

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sterlin Morris Retirement Associates LTD Partnership	100%	Coventry Village	Sterling, IL	Harris Webber LTD	Northbrook, IL	R.E. Development

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Management Fee	\$ 282,512	Harris Webber LTD		\$ 322,870	\$ 40,358	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 282,512			\$ 322,870	\$ * 40,358	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Walnut Grove Village # 0033506 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Harris F. Webber	General Partner	President	Genl Ptnr	94,878	681	32.76	Salary	\$ 99,490	Line17Col 7	1
2	Myra A. Webber	Treasurer	Clerical Support	0.00	5,272	341	32.76	Salary	5,529	Line17Col 7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 105,019		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Walnut Grove Village# 0033506

Report Period Beginning:

1/01/2002Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Harris Webber, LTDStreet Address 666 Dundee Road, Suite 930City / State / Zip Code Northbrook, IL 60062Phone Number (847) 272-9686Fax Number (847) 272-0524

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 Heat & Other Utilities	Direct Cost	14,984,208	5	\$ 5,645	\$	4,909,130	\$ 1,849	1
2	6 Maintenance	Direct Cost	14,984,208	5	10,248		4,909,130	3,357	2
3	11 Activities	Direct Cost	14,984,208	5	1,068		4,909,130	350	3
4	17 Administrative	Direct Cost	14,984,208	5	701,748	701,748	4,909,130	229,907	4
5	19 Professional Services	Direct Cost	14,984,208	5	19,040		4,909,130	6,238	5
6	20 Fees, Subscriptions & Promotions	Direct Cost	14,984,208	5	4,525		4,909,130	1,482	6
7	21 Clerical&General Office Exp	Direct Cost	14,984,208	5	26,471		4,909,130	8,672	7
8	22 Employee Benefits&Payroll	Direct Cost	14,984,208	5	75,511		4,909,130	24,739	8
9	24 Travel & Seminar	Direct Cost	14,984,208	5	2,804		4,909,130	919	9
10	26 Insurance - Prop, Liab, Mal	Direct Cost	14,984,208	5	13,213		4,909,130	4,329	10
11	30 Depreciaton	Direct Cost	14,984,208	5	40,045		4,909,130	13,120	11
12	32 Interest	Direct Cost	14,984,208	5	2,472		4,909,130	810	12
13	34 Rent-Facility & Grounds	Direct Cost	14,984,208	5	73,900		4,909,130	24,211	13
14	35 Rent-Equipment & Vehicles	Direct Cost	14,984,208	5	8,813		4,909,130	2,887	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 985,503	\$ 701,748		\$ 322,870	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

Schedule A (Complete details are required for each item listed in separate columns below)																
	1	2	3	4	5	6		7	8	9	10					
						Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
							YES	NO				Original	Balance			
	A. Directly Facility Related Long-Term															
1	National City Bank		x	Mortgage	\$33,452.00	11/07/87	\$ 3,068,522	\$ 1,761,723	12/01/08	8.7500	\$ 166,853	1				
2	National City Bank		x	Mortgage	\$15,403.00	02/01/94	1,788,002	1,204,748	11/01/08	10.0000	67,089	2				
3	First Midwest Bank		x	Van	\$1,034.50	04/01/99	51,642	14,693	03/31/04	7.2500	1,510	3				
4												4				
5												5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related				\$49,889.50		\$ 4,908,166	\$ 2,981,164			\$ 235,451	9				
	B. Non-Facility Related*															
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$				\$	14				
15	TOTALS (line 9+line14)						\$ 4,908,166	\$ 2,981,164			\$ 235,451	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

						<i>Important</i> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2001 report.								\$	76,205	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)								\$	76,205	2
3. Under or (over) accrual (line 2 minus line 1).								\$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)								\$	78,214	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)								\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.										
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)								\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.								\$	78,214	7
Real Estate Tax History:										
Real Estate Tax Bill for Calendar Year:		1997	115,418	8	<div style="float: right; border: 1px solid black; padding: 5px;"> FOR OHF USE ONLY </div>					
		1998	125,000	9						
		1999	60,519	10						
		2000	82,721	11						
		2001	76,205	12						
					13	FROM R. E. TAX STATEMENT FOR 2001	\$		13	
					14	PLUS APPEAL COST FROM LINE 5	\$		14	
					15	LESS REFUND FROM LINE 6	\$		15	
					16	AMOUNT TO USE FOR RATE CALCULATION \$			16	

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walnut Grove Village COUNTY Grundy

FACILITY IDPH LICENSE NUMBER 0033506

CONTACT PERSON REGARDING THIS REPORT Mark Hull

TELEPHONE (574) 239-7883 FAX #: (574) 239-7871

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>02-33-301-005</u>	<u>Beattys West Estates</u>	\$ <u>130,068.00</u>	\$ <u>78,214.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>130,068.00</u>	\$ <u>78,214.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Walnut Grove Village

0033506

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99		1989	\$ 2,058,454	\$ 51,461	40	\$ 51,461	\$	\$ 711,723
5	24		1994	1,599,312	39,950	40	39,950		326,361
6									
7									
8									
Improvement Type**									
9	Land Improvements		1989	257,750	17,183	15	17,183		237,698
10	Land Improvements		1990	7,161	477	15	477		5,968
11	Land Improvements		1991	9,360	624	15	624		7,176
12	Land Improvements		1992	11,484	517	10	517	0	11,484
13	Land Improvements		1993	2,918	292	10	292		1,413
14	Land Improvements		1994	5,402	360	15	360		3,061
15	Land Improvements - Trees		1996	1,275	85	15	85		714
16	Land Improvements - Seal Coating		1997	5,268	659	8	659		2,515
17	Land Improvements - Benches/Trees		1997	1,836	92	20	92		414
18	Land Improvements - Shrubs		1997	2,093	419	5	419		1,885
19	Land Improvements - Street Paving & Driveway		1998	3,971	496	8	496		1,736
20	Land Improvements - Ditch Work		1998	3,500	233	15	233		1,050
21	Land Improvements - Trees		1998	5,518	276	20	276		1,242
22	Land Improvements - Driveway & Parking Lot		2000	45,941	5,743	8	5,743		25,579
23	Land Improvements - Driveway Extension		2000	780	52	15	52		182
24	Land Improvements - Black Dirt		2000	625	125	5	125		313
25	Land Improvements - Plants for Campus		2001	654	131	5	131		196
26									
27									
28	Building Improvements		1994	11,198	1,120	10	1,120		9,478
29	Building Improvements		1995	38,145	3,815	10	3,815		27,632
30	Building Improvements - Carpet		1996	5,250	525	10	525		3,414
31	Building Improvements - Carpet		1997	4,808	962	5	962		2,558
32	Building Improvements - Doors & Kickplates		1998	12,600	1,260	10	1,260		5,670
33	Building Improvements - Air Conditioner		1999	2,531	253	10	253		885
34	Building Improvements - Diffuser		1999	9,696	970	10	970		3,395
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Building Improvements - Heat Pumps	2001	\$ 660	\$ 132	5	\$ 132	\$	\$ 198	37	
38	Building Improvements - Pump	2001	1,655	166	10	166		249	38	
39	Building Improvements - Door Code Lock	2001	824	82	10	82		123	39	
40	Building Improvements - Diesel Generator	2001	1,265	252	5	252		379	40	
41	Building Improvements - Doors	2001	1,041	208	5	208		312	41	
42	Building Improvements - Door Locks	2001	628	126	5	126		188	42	
43	Building Improvements - Telephone System	2001	7,782	1,556	5	1,556		2,334	43	
44	Building Improvements - Heat Pumps	2001	2,312	462	5	462		694	44	
45	Building Improvements - Tile - Villa Dining Room	2001	1,310	262	5	262		393	45	
46	Building Improvements - Tile - Front Dining Room	2001	1,498	300	5	300		450	46	
47	Building Improvements - Lights in Garage	2001	1,420	284	5	284		426	47	
48	Building Improvements - Water Heater for Villa	2001	2,907	581	5	581		872	48	
49	Building Improvements - Compressors	2002	2,612	261	5	261		261	49	
50	Building Improvements - Heat Pumps	2002	2,929	293	5	293		293	50	
51	Building Improvements - Single/Double Door System	2002	1,619	162	5	162		162	51	
52									52	
53									53	
54									54	
55									55	
56									56	
57									57	
58									58	
59									59	
60									60	
61									61	
62									62	
63									63	
64									64	
65									65	
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 4,137,992	\$ 133,207		\$ 133,207	\$ 0	\$ 1,401,076	70	

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 398,317	\$ 44,752	\$ 44,752	\$		\$ 279,820	71
72	Current Year Purchases	12,821	772	772			772	72
73	Fully Depreciated Assets	817,406					817,406	73
74								74
75	TOTALS	\$ 1,228,544	\$ 45,524	\$ 45,524	\$		\$ 1,097,998	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van	Ford, Eldorado, 1999	1999	\$ 51,542	\$ 10,308	\$ 10,308	\$		\$ 36,009	76
77										77
78										78
79										79
80	TOTALS			\$ 51,542	\$ 10,308	\$ 10,308	\$		\$ 36,009	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,695,763	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 189,039	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 189,039	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,535,083	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottages - 1989-2000	\$ 3,298,798	\$ 82,981	\$ 563,474	86
87	Cottages Land Imp - 1989-2000	50,822	2,863	26,155	87
88	Cottages - FFE - 1989-2000	45,391	3,131	33,574	88
89	Cottages - Bldg Imp - 1995-2000	24,905	2,399	6,367	89
90					90
91	TOTALS	\$ 3,419,916	\$ 91,374	\$ 629,570	91

G. Construction-in-Progress

	Description	Cost	
92	Apartments	\$ 58,636	92
93			93
94			94
95		\$ 58,636	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Ending: 12/31/2002

A. Building and Fixed Equipment (See instructions.)

N/A

If NO, see instructions.

☐ YES ☐ NO

10. Effective dates of current rental agreement:

Ending

Fiscal Year Ending	Annual Rent
--------------------	-------------

11

YES

NO

Terms: *

✱

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

\$ 21,718

Description:

(Attach a schedule detailing the breakdown of movable equipment)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	139	\$ 127,939	\$	139	\$ 127,939	1
2	Licensed Speech and Language Development Therapist		hrs		19	19,674	1,066	19	20,740	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		159	146,219		159	146,219	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		1626 hrs	20,004				1,626	20,004	8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 20,004	317	\$ 293,832	\$ 1,066	1,943	\$ 314,902	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Walnut Grove Village

0033506

Report Period Beginning: 1/01/2002

Ending:

12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 295,164	\$	1
2	Cash-Patient Deposits	4,322		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (94,220))	1,013,221		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,553		6
7	Other Prepaid Expenses	1,250		7
8	Accounts Receivable (owners or related parties)	666,658		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,046,168	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	277,685		13
14	Buildings, at Historical Cost	7,526,065		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,325,477		16
17	Accumulated Depreciation (book methods)	(3,159,157)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	58,636		22
23	Other(specify): <u>Loan Fees Net</u>	75,716		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,104,422	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,150,590	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 470,750	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	262,147		28
29	Short-Term Notes Payable	343,042		29
30	Accrued Salaries Payable	146,291		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	139,542		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Related Party</u>	10,367		36
37	<u>Other Accruals</u>	77,300		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,449,439	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,638,122		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Cottage Deferred Income</u>	3,315,214		43
44	<u>Entrance Fee Liability</u>	296,684		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,250,020	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,699,459	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 451,131	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,150,590	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 135,113	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 135,113	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	316,021	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 316,018	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 451,131	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Walnut Grove Village

0033506

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,640,770	1
2	Discounts and Allowances for all Levels	(489,415)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,151,355	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	790,653	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 790,653	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,838	13
14	Non-Patient Meals	3,169	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	146,411	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	14,066	20
21	Other Medical Services	9,441	21
22	Laundry	17,681	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 213,606	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,218	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,218	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Cottages	253,719	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 253,719	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,414,551	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	950,416	31
32	Health Care	1,981,347	32
33	General Administration	1,212,587	33
B. Capital Expense			
34	Ownership	527,238	34
C. Ancillary Expense			
35	Special Cost Centers	381,652	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37	Rounding	(5)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,107,438	40
41	Income before Income Taxes (line 30 minus line 40)**	307,113	41
42	Income Taxes	8,908	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 316,021	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Walnut Grove Village# 0033506Report Period Beginning: 1/01/2002Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,480	162	\$ 37,692	\$ 25.47	1
2	Assistant Director of Nursing	2,024	136	48,109	23.77	2
3	Registered Nurses	9,444	740	281,084	29.76	3
4	Licensed Practical Nurses	18,753	1,342	358,325	19.11	4
5	Nurse Aides & Orderlies	60,378	4,717	699,668	11.59	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,072	88	23,547	11.36	9
10	Activity Assistants	5,787	161	43,770	7.56	10
11	Social Service Workers	3,660	424	68,308	18.66	11
12	Dietician					12
13	Food Service Supervisor	2,380	180	35,678	14.99	13
14	Head Cook	5,455	420	56,606	10.38	14
15	Cook Helpers/Assistants	11,226	746	91,381	8.14	15
16	Dishwashers					16
17	Maintenance Workers	6,930	510	82,011	11.83	17
18	Housekeepers	17,859	1,363	160,188	8.97	18
19	Laundry	5,449	525	50,654	9.30	19
20	Administrator	1,904		94,895	49.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,080	445	93,615	15.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	1,626	275	20,004	12.30	30
31	Medical Records	1,984	145	18,337	9.24	31
32	Other Health C: Cottages	10,402	482	27,975	2.69	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,893	12,861	\$ 2,291,847 *	\$ 13.10	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	266	\$ 10,099	Ln 1 Col 3	35
36	Medical Director		10,200	Ln 9 Col 3	36
37	Medical Records Consultant			Ln 10 Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,400	Ln 39 Col 3	39
40	Physical Therapy Consultant	139	146,219	Ln 10a Col 3	40
41	Occupational Therapy Consultant	19	127,939	Ln 10a Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	59	19,674	Ln 10a Col 3	43
44	Activity Consultant	43	2,256	Ln 11 Col 3	44
45	Social Service Consultant	13	798	Ln 12 Col 3	45
46	Other(specify)				46
47	Barber/Beauty		20,754	Ln 40 Col 3	47
48	Lab Service		4,639	Ln 10a Col 3	48
49	TOTAL (lines 35 - 48)	539	\$ 346,978		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **Walnut Grove Village**# **0033506**Report Period Beginning: **1/01/2002**Ending: **12/31/2002****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description	Amount	Description	Amount		
Ken Jepsen	Administrator	n/a	\$ 36,511	Workers' Compensation Insurance	\$ 129,912	IDPH License Fee	\$ 200		
Michele Brousek	Administrator	n/a	58,384	Unemployment Compensation Insurance		Advertising: Employee Recruitment	5,524		
				FICA Taxes	187,217	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance	126,807	Other Licenses	242		
				Employee Meals		Dues and subscriptions	3,431		
				Illinois Municipal Retirement Fund (IMRF)*					
				Life Insurance	3,450				
				Other Emp. Benefits	37,605				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,895			Less: Public Relations Expense	()		
B. Administrative - Other						Non-allowable advertising	()		
Description			Amount			Yellow page advertising	(142)		
HWMS	Management Fee		\$ 282,512						
Harris F. Webber	Partnership Fee		7,500						
Harris F. Webber	Guarantee Fee		7,500						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 297,512						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Wildman Harrold - HW LTD	Legal		\$ 49				Out-of-State Travel	\$	
Rosenthal & Schanfield - HW LTD	Legal		290						
Much Shelist Freed Denenberg	Legal		4,747						
Wildman, Harrold, Allen & Dixon	Legal		7,070				In-State Travel	6,554	
Mr. John Hanson	Legal		2,500						
Crowe Chizek & Co. LLP	Accounting		23,150						
Advanced Answers on Demand	Computer Services		6,624						
Ivans	Computer Services		1,306				Seminar Expense	1,011	
Adminastar Federal Inc	Computer Services		120				Other seminars	1,695	
Harris Webber LTD - Q.LeGrand	Computer Services		75						
ADP	Payroll Services		9,986						
State of IL Office of the State	Other		570				Entertainment Expense	(692)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 56,487	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 8,568	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Heat Pump	6/94	\$ 1,201	7	\$ 172	\$ 172	\$ 86	\$	\$	\$	\$	\$	\$
2	Phone System	6/94	659	7	94	94	47						
3	Relay Board	6/94	1,100	7	157	157	79						
4	Panel Cords	6/94	965	7	138	138	69						
5	Heat Pump	6/94	1,091	5	218	109							
6	No additions in 1997												
7	No additions in 1998												
8	No additions in 1999												
9	No additions in 2000												
10	No additions in 2001												
11	No additions in 2002												
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 5,016		\$ 779	\$ 670	\$ 281	\$	\$	\$	\$	\$	\$

Facility Name & ID Number **Walnut Grove Village**

STATE OF ILLINOIS

0033506

Report Period Beginning:

1/01/2002

Ending:

Page 23

12/31/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. \$3,161 Ill Health Care Assoc.
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,207 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,169
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Crowe Chizek & Co. LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not complete as of filing date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.